DELAWARE HEALTH AND SOCIAL SERVICES
Division of Long Term Care Residents Protection

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 577-6661

STATE SURVEY REPORT

NAME OF FACILITY: Luther Towers Assisted Living

DATE SURVEY COMPLETED: July 2, 2012

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	An unannounced annual and complaint survey was conducted at this facility beginning June 27, 2012 and ending July 02, 2012. The facility census on the entrance day of the survey was 31. The survey sample was composed of 4 residents. The survey process included observations, interviews and review of residents' clinical records, facility documents and facility policies and procedures.	
3225.13.0	**Service Agreements**	3225.13.5
3225.13.5	**The service agreement shall be developed and followed for each resident consistent with that person's unique physical and psychosocial needs with recognition of his/her capabilities and preferences.**	1. Resident #3 has been discharged to a skilled nursing facility. At the time of her assessment, she was not determined to be an elopement risk. When the Service Agreement was developed, the daughter was questioned about the monitoring bracelet and she said she had the bracelet put in place by the New Castle County Police for her peace of mind in theevent her mother ever became an elopement risk in the future. She was not concerned about this at the time.
	This requirement is not met as evidenced by:	2. The facility has reviewed the assessments of all current residents and determined none are an elopement risk.
	Based on clinical record reviews and staff interviews it was determined that the facility developed a service agreement that failed to address the risk of elopement and an actual elopement exhibited by one resident (Resident #3) out of four sampled. Findings include:	3. When assessments are done and reviewed by the Director of Nursing and facility Administrator, any applicant deemed to be an elopement risk are denied admission. We do not have the necessary facilities to keep such residents from leaving the facility. If a current resident is deemed to be an elopement risk, proper safety precautions are put in place andthe facility immediately works with the family to find an appropriate placement.
	Cross refer 3225.19.7, 3225.19.7.5. Review of the clinical record revealed that the facility developed a service agreement dated 7/6/2011 without goals and time frames and specific interventions that addressed or monitored the risk of elopement prior to or following the actual elopements exhibited by Resident #3.	4. Each resident admitted will be monitored for a period of two weeks for the possibility of elopement. This has been added to the Service Agreement and will be added to the Weekly Care Log at the time of admission. See **Attachment "A"**
	This finding was reviewed with E1	**Completion date: September 1, 2012**

Provider's Signature Judith L. Thompson, NHA Title Administrator Date 8/16/12

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	(executive director) and E2 (administrator) on 7/2/2012.	
3225.13.6	**The service agreement shall be reviewed when the needs of the resident have changed and, minimally, in conjunction with each UAI. Within ten days of such assessment, the resident and the assisted living facility shall execute a revised service agreement if indicated.** **This requirement is not met as evidenced by:** Based on clinical record review and staff interview it was determined that the facility failed to execute a service agreement within 10 days of an annual UAI assessment developed for two residents (Resident #2 and Resident #4)) out of 4 sampled. Findings include: 1. Review of Resident #2's clinical record revealed the absence of an annual service agreement dated 2012 in conjunction with the annual UAI dated 6/6/2012. This finding was reviewed with E1 (executive director) and E2 (administrator) on 7/2/2012. 2. Review of Resident #4's clinical record revealed the absence of an annual service agreement dated 2010 in conjunction with the annual UAI dated 8/3/2010. This finding was reviewed with E1 (executive director) and E2 (administrator) on 7/2/2012.	3225.13.6 1. The Service Agreement has been update for Residents #2 and #4. 2. Service agreements for all residents have been reviewed and determined to be up to date. 3. To ensure this does not occur in the future, the nurse who does the UAI will be assigned to also do the service agreement. 4. An audit will be done quarterly and presented to the Quality Assurance Committee by the Director of Nursing concerning the timeliness of UAIs and service agreements. **Completion date: September 1, 2012**
3225.18.0 3225.18.4	**Fire Safety and Other Emergency Plans** **The assisted living facility shall**	

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3225.18.4.3	**promote staff knowledge of fire and other emergency safety by:** **Conducting facility fire drills in accordance with State of Delaware Fire Prevention Regulations;** **This requirement is not met as evidenced by:** Based on review of facility documents, staff interview and facility policy it was determined that the facility failed to conduct fire drills in accordance with State of Delaware Fire Prevention Regulations. Findings include: Review of facility documents revealed the absence of recorded fire drills conducted on a quarterly basis on all shifts beginning with the last half of the year 2010, the year of 2011 and first half of the year 2012 for assisted living residents residing in both buildings. Further review of facility documents revealed the building, shift, quarter and year fire drills were conducted: Building I: day shift, 3rd quarter, 2011. Building I: evening shift, 4th quarter, 2011. Building I: night shift, 4th quarter, 2011. Building I: day shift, 2nd quarter, 2012. Building I: evening shift, 2nd quarter, 2012. Building I: night shift, 2nd quarter, 2012. Building II: evening shift, 4th quarter, 2011. Building II: night shift, 4th quarter, 2011. Building II: day shift, 2nd quarter, 2012. The facility failed to conduct fire drills in accordance with State of Delaware Fire Prevention Regulations. Review of the facility policy "Fire Safety Plan" states "...Fire drills will be conducted on a quarterly basis...".	3225.18.4.3 On August 16, 2011, the facility and the Wilmington Fire Marshall's Office reached an agreement whereby that office would conduct periodic Unannounced emergency egress drills. One such drill was conducted two days later, and none were conducted by that office since then. Nonetheless, in accordance with that agreement, the facility will conduct quarterly silent drills on all three shifts and will report the outcomes of these drills to the Quality Assurance Committee on a quarterly basis. The Committee will monitor this process to ensure the deficient practice does not recur. **Please see Attachment "B"** **Completion date: September 1, 2012**

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	These findings were reviewed with on E1 (executive director) and E2 (administrator) on 7/2/2012.	
3225.18.4.5	**Maintaining records for two years of facility fire and other emergency drills/training sessions.** **This requirement is not met as evidenced by:** Based on review of facility documents and staff interview it was determined that the facility failed to maintain two years of facility fire drills. Findings include: In an interview conducted with E2 (administrator) on 6/28/2012 it was confirmed that the facility lacked documentation of the performance of fire drills for all shifts and quarters during the last half of the year 2010, the year 2011 and the first half of the year 2012. The facility failed to maintain two years of facility fire drills conducted on all shifts on a quarterly basis from June 1, 2010 through May 31, 2012. These findings were reviewed with E1 (executive director) and E2 (administrator) on 7/2/2012.	3225.18.4.5 The facility has begun regular documentation of quarterly fire drills which will be turned over to the Quality Assurance Committee on a quarterly basis for review. These documents will be maintained in the office of E2 (administrator) for three years. **Please see attachment "B"** **Completion date: September 1, 2012**
3225.19.0	**Records and Reports**	
3225.19.6	**Reportable incidents shall be reported immediately, which shall be within 8 hours of the occurrence of the incident, to the Division. The method of reporting shall be directed by the Division.** **This requirement is not met as evidenced by:** Based on clinical record review and staff	

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	interview it was determined that the facility failed to immediately report an incident of elopement exhibited by one resident (Resident #3) and another incident of burns greater than first degree sustained by one resident (Resident #4) out of four sampled within 8 hours to the Division. Findings include: 1. Cross refer 3225.19.7, 3225.19.7.5. Review of an incident report submitted to the Division on 4/20/2012 at 14:51 PM revealed it was received approximately 19 hours following the elopement of Resident #3 from the facility. According to the incident report Resident #3 was discovered missing on 4/19/2012 at the time [between 9:30PM and 10 PM] E5 (AWSAM staff member) entered her apartment to assist with the self-administration of medications. A search of the interior and exterior of the building with family members and police failed to immediately locate Resident #3. At approximately 2:30 AM on 4/20/2012 Resident #3 was located by a family member and transported to an acute care facility for evaluation before returning to the assisted living facility. The facility failed to immediately report the elopement of Resident #3 within 8 hours to the Division. This finding was reviewed with E1 (executive director) and E2 (administrator). 2. Review of a facility incident report submitted to the Division on 3/15/2011 at (9:00 AM) revealed it was received approximately 2 weeks after Resident #4 was scalded with hot chocolate on	**3225.19.6** 1. Both residents have been discharged prior to the survey. 2. The most recent of these involved Resident #3. Since that incident, there has only been one reportable incident cited below concerning Resident #2 and it was reported within 8 hours to the Division as required. 3. Both the Director of Nursing and the Administrator have reviewed the electronic reporting process and have a process in place so this can be done not only from the facility, but remotely when needed to meet the 8 hour time frame. 4. The Administrator will report on a quarterly basis to the facility Quality Assurance Committee the date and time of all reportable incidents and the date and time the report was sent to the Division during the reporting quarter. **Completion date: September 1, 2012**

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	3/2/2012 at 8:30 AM. Additionally the above incident report revealed that Resident #4 was transported and admitted to an acute care facility and diagnosed with second degree burns of the left chest, lower abdomen and bilateral thighs. The facility failed to immediately report this incident of burns greater than first degree sustained by Resident #4 within 8 hours to the Division. This finding was reviewed with E1 (executive director) and E2 (administrator).	
3225.19.7	**Reportable incidents include:**	
3225.19.7.2	**Neglect as defined in 16 Del.C 1131.** **16 Del., C., Chapter 11, Subchapter III** **Subchapter III. Abuse, Neglect, Mistreatment or Financial Exploitation of Residents or Patients** **Section 1131. Definitions.** **When used in this subchapter the following words shall have the meaning herein defined. To the extent the terms are not defined herein, the words are to have their commonly-accepted meaning.** **(9) "Neglect" shall mean:** **a. Lack of attention to physical needs of the patient or resident including, but not limited to toileting, bathing, meals and safety.** **This requirement is not met as evidenced by:** Based on clinical record review, review of	

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	facility documents and staff interview it was determined that the facility failed to provide a safe environment for one resident (Resident #3) out of four sampled who eloped from the facility without the knowledge of staff. Findings include: Review of the clinical record revealed that Resident #3 was initially admitted to the assisted living facility on 7/6/2011 with diagnoses that included dementia and hypertension. According to the initial UAI dated 6/17/2011 Resident #3 was oriented to self and place, experienced short-term memory problems and was independent in ADLs (activities of daily living). Although the above referenced UAI revealed absence of wandering Resident #3 was assessed wearing "a wristband (that) alerts police if she wanders off" as she was enrolled in the "Adult Alert Program" that aids in the location of missing adults with mental impairment. Further review of the clinical record revealed that Resident #3 actually eloped from the facility and attempted elopement from the facility on the dates of 4/23/2012 at (9:00 PM and 9:30 PM) and 4/27/2012 at (8:20 PM). Additionally a completed "Monthly Wellness Visit" form dated 5/10/2012 stated "...Did have an episode of exit-seeking. Very easy to redirect...". Another "Monthly Wellness Visit" form dated 5/13/2012 stated "(Resident #3) has been on fifteen minute spot checks following her elopement. The "Monthly Wellness Visit" form dated June 5, 2012 stated "(Resident #3) continues to be monitored and eye checked (every) 30 (minutes). (Resident #3) managed to walk off again twice this month, but was readily apprehended before she could cross the street or get very far from the facility...".	3225.19.7.2 1. Resident #3 was discharged to a SNF prior to the survey. As stated above under 3225.13.5, the resident's daughter was not concerned about elopement in the immediate future and had the wristband put on her mother for her peace of mind in the future. The nursing assessment did not reveal any elopement concerns. Even though the initial service agreement dated 6/28/11 indicated the resident needed supervision for safety, this is a remark made on most service agreements referring to our need to provide a safe environment for all residents and was not making a reference to a specific concern. Once the elopement occurred, 30 minute face checks were immediately initiated and recorded. The facility met with the family to initiate discharge planning to an appropriate facility and to enlist the aid of the family in monitoring the resident. In addition, the front desk security guards were alerted about the situation. 2. The facility has reviewed the assessments of all current residents and determined none are an elopement risk. 3When assessments are done and reviewed by the Director of Nursing and facility Administrator, any applicant deemed to be an elopement risk is denied admission. We do not have the necessary facilities to keep such residents from leaving the facility. If a current resident is deemed to be an elopement risk, proper safety precautions are put in place and the facility immediately works with the family to find an appropriate placement. 5. Each resident admitted will be monitored for a period of two weeks for the possibility of elopement. This has been added to the Service Agreement and will be added to the Weekly Care Log at the time of admission. **Please see Attachment "A"** **Completion date: September 1, 2012**

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	The facility failed to provide a safe environment in accordance with the service agreement for Resident #3. Review of facility incident reports revealed that Resident #3 eloped from the facility on 4/19/2012 without the knowledge of staff. Review of attachments to the incident report dated 4/20/2012 and timed 8:30 AM revealed that Resident #3 was last observed heading toward her room after eating dinner in the dining room before staff was aware of elopement from the facility between 9:30 PM and 10:00 PM on 4/19/2012. Resident #3 was eventually found by a family member on 4/20/2012 at approximately 2:30 AM according to the above referenced incident report attachments. Further review of the incident report dated 4/20/2012 revealed that Resident #3 was reported missing when her room was found empty by E5 (AWSAM staff member) who entered the resident's room between 9:30 PM and 10:00 PM to assist with self-administration of medications. After searching the facility E5 (AWSAM staff member) telephoned E3 (RN/ DON) between 10:00 PM and 10:30 PM and informed her of the elopement of Resident #3. The resident's family and county police were notified of Resident #3's elopement and an extensive search was conducted outside of the facility. The above referenced incident report also stated that the police were unable to detect the location of Resident #3 due to the lack of appropriate equipment. At approximately 2:30 AM Resident #3 was located by a family member and returned to the facility. However the family members decided to transport Resident #3 to an acute care facility for an evaluation.	

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	Following discharge from the acute care facility Resident #3 was returned to the assisted living facility at 4:00 AM on 4/20/2012. Upon the return of Resident #3 the facility "initiated 30 minute face checks around the clock". Review of the clinical record revealed the initial service agreement dated 6/28/2011 indicated Resident #3 required supervision for safety. The facility failed to provide a safe environment in accordance with the service agreement for Resident #3. This finding was reviewed with E1 (executive director) and E2 (administrator).	
3225.19.7	**Reportable incidents include:**	
3225.19.7.2	**Neglect as defined in 16 Del.C 1131.** **16 Del., C., Chapter 11, Subchapter III** **Subchapter III. Abuse, Neglect, Mistreatment or Financial Exploitation of Residents or Patients** **Section 1131. Definitions.** **When used in this subchapter the following words shall have the meaning herein defined. To the extent the terms are not defined herein, the words are to have their commonly-accepted meaning.** **(9) "Neglect" shall mean:** **b. Failure to report patient or resident health problems or changes in health problems or changes in health condition to an immediate supervisor or nurse.**	

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	This requirement is not met as evidenced by: Based on clinical record review and staff interview it was determined that the AWSAM staff member failed to immediately notify the nurse of a shortage of medication to address the pain of one resident (Resident #2) out of four sampled. Findings include: Review of a completed facility incident report dated 6/15/2012 and timed 2:15 AM revealed that E5 (AWSAM staff member) assisted Resident #2 with self-administration of a medication that was removed from a blister pack labeled for Resident #1. Additionally E5 (AWSAM staff member) awarded documentation of assistance with self-administration of medication to Resident #1's MAR dated 06/01/2012 rather than Resident #2. Further review of the above referenced incident report revealed attachments which included a statement from E5 (AWSAM staff member) that acknowledged she removed 1 tablet of a medication from the blister pack of Resident #1 in order to assist Resident #2 with self-administration of a medication for pain at 12:00 PM on 6/14/2012. In an interview with E2 (administrator) on 6/27/2012 he stated that the supply of Resident #2's pain medication was exhausted on 6/14/2012 at 3:00 AM and without a refill. Therefore E5 (AWSAM staff member) removed one tablet of Resident #1's medication, with same name and dosage, to assist Resident #2 with self-administration of the medication for pain at 12:00 PM on 6/14/2012. During the same interview E2 (administrator) stated he learned of the incident on 6/15/2012 when	**3225.19.7.2** 1. Neither Resident #1 or #2 suffered any harm as a result of this action. In addition, E5 (AWSAM staff member) resigned on 6/15/12 during the course of the investigation upon admitting her actions. 2. A Nursing Staff Meeting was held on August 9, 2012. During the meeting, the Director of Nursing reviewed the standard regulatory process of never sharing medications between residents, properly documenting on the MAR, and always calling the nurse when there is a question or problem with a medication. Also, the need to notify a nurse when medications need to be reordered from the pharmacy was reviewed. 3. A selected licensed nursing staff member will conduct quarterly audits of the medication cards to ensure a nurse has been notified in a timely manner when medications need to be reordered. 4. The Director of Nursing will report to the Quality Assurance Committee on a quarterly basis as to the results of these audits. **Please see Attachment "C"** **Completion date: September 1, 2012**

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	he was informed by E6 (licensed staff member) that Resident #1 denied pain and a request for pain medication at 12:00 PM on 6/14/2012. E2 (administrator) further stated that after an interview with Resident #2 who confirmed she received a pain tablet "around 12:00 PM" on 6/14/2012 he confronted E5 (AWSAM staff member). When E5 (AWSAM staff member) was informed of statements received from Resident #1 and Resident #2 she admitted to removing a medication from the blister pack labeled for Resident #1 in order to assist Resident #2 with self-administration of a medication which transaction she then documented on the MAR dated 06/01/2012 through 06/30/2012 of Resident #1. Following this exchange E2 (administrator) stated E5 (AWSAM staff member) resigned immediately on 6/15/2012. In another interview conducted with E2 (administrator) on 7/2/2012 he confirmed that E5 (AWSAM staff member) failed to obtain direction from licensed staff prior to assistance with self-administration of medications on 6/14/2012. The facility failed to ensure that the nurse was notified of a shortage of medication to address pain experienced by Resident #2.	